CareSource™

CareSource Provider/Group Change Request Form

Date: _____ PR Representative: _____	❑ Add a Provider (Adding a provider to a participating group) ❑ Delete a Provider (Deleting a provider from a participating group) ❑ Demographic Change (Ex. Practice location change, specialty change, NPI/phone/fax change, product add/delete, capacity, restrictions) *Details regarding any of the above changes can be placed in Notes on Page 2*					
Group IRS Name						
Group DBA						
Group TIN						
Group NPI						
Group Medicare #						
Group Medicaid #						
Product: Medicaid and/or SNP (Medicare)	❑ Medicaid Only	❑ Medicaid and SNP	❑ SNP Only	❑ MyCare	❑ Just4Me	❑ All Products
Please indicate if you are:	❑ FQHC	❑ RHC	❑ QFPP	❑ CMHC		
OFFICE CONTACT						
Contact Name						
Contact Phone						
Contact Email						
CONTRACT						
Signatory Name						
Signatory Title						
Signatory Email						
ADDRESS						
Remit Name						

Remit	Street		City		State		Zip	
Mailing ❑ Same as above	Street		City		State		Zip	
Contractual Updates ❑ Same as above	Street		City		State		Zip	

For Internal Use Only: Medicaid Agreement ID _____

For Internal Use Only: Medicare Agreement ID _____

PROVIDER INFORMATION

Name/Degree	Street Address	City	State/County	Zip + 4	Phone	Fax	NPI #	CAQH #	Medicaid #	Medicare #	Specialty	PCP ? Y/N	If Yes, Capacity ?	Age Restrictions
John Doe MD (SAMPLE)	123 N. Main St.	Anywhere	OH/Montgomery	45123-1234	937-555-1212	937-555-1212	1231231291	123456	1234567	1234567	FP	Y	100	

NOTES:

Important: Please include W-9 and ensure all CAQH applications are updated and accurate to ensure timely processing of providers.

Return to: Your CareSource Provider Relations Representative or send to providermaintenance@CareSource.com or fax to 937-396-3076